STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN46342

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/13/11 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Serbo's Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	This facility was surveyed as three separate buildings due to the construction types of three sections of the building. Building 0102 was originally built as a house in 1951 and is of Type V (000) construction and is fully sprinklered. Building 0202 was renovated in 1972 and 1999 and was determined to be of Type II (111) construction and was not sprinklered. Building 0302 was determined to be of Type V (111) construction and was fully sprinklered, built in 1999 and encompasses the north and southeast sections of the facility. The facility has two fire alarm systems with smoke detection in the corridors and spaces open to the corridors. The facility has smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 122 at the time of this survey. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 04/19/11.			

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0021	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2			
SS=E	Based on observation and interview, the facility failed to ensure doors serving 3 of 12 hazardous areas were held open only by devices arranged to automatically close the door upon activation of the fire alarm system. This deficient practice affects all staff in and near the facility's laundry room, nursing supply storage room and the kitchen.	K0021	K021 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility removed the wedges from laundry room door, nursing supply storage room, and the kitchen door. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The facility audited all doors to ensure wedges were not being used. Any wedges noted were removed and	05/13/2011

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	Findings include: Based on observations on 04/13/11 with the maintenance supervisor and facility administrator between 11:10 a.m. and 1:20 p.m. the laundry room door, nursing supply storage room door and the kitchen door were blocked open with wedges. The maintenance supervisor stated at the time of the observations he was not aware of the problem and wedges were used frequently in the facility. 3.1-19(b)		employees were reminded not to use wedges. The administrator reviewed with department managers at the end of day meeting on not to use door wedges. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Door wedges were removed from the laundry, dietary and nursing supply areas. · Staff were in-serviced on the importance of not using a wedge to hold a door open and that doors must remain closed to rooms that contain hazardous materials, i.e. laundry, dietary and nursing supply. · Automatic closures were removed from doors that did not have access to hazardous materials eliminating the need for a door wedge. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Weekly the Administrator/ designee will audit ten doors to ensure that door wedges are not in use and any door for a hazardous area is held open by a device arranged to automatically close. A summary of the audits will be presented to the Quality Assurance committee monthly by Administrator/designee for three	

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			months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Compliance Date: 5/13/2011	
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets were arranged to automatically close and latch. LSC section 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice affects all residents, staff and visitors in the facility's main resident corridor near rooms 1 and 2.	K0044	K044 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The latch for fire door located on the corridor near rooms 1 and 2 has been replaced.. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All residents residing on Cherry Lane unit have the potential of being affected by the alleged deficient practice. · The door latch has been replaced. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · The Maintenance Director/designee will include the door latches on the regular facility door inspections already in place. How will the corrective actions(s) be	05/13/2011

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	Findings include: Based on observation with the maintenance supervisor and facility administrator on 04/13/11 at 2:15 p.m. the fire doors to the main resident corridor near rooms 1 and 2 did not close completely and did not latch. The maintenance supervisor stated at the time of observation the mechanism which should latch the door closed was broken. 3.1-19(b)		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The Maintenance Director/designee will complete/review door inspections for any work/repairs needed and ensure timely completion. · Any findings of work/repairs needed will be reported to the Administrator/Corporate Plan Director to assure compliance during time of repair to completion. · Work/repairs will be reviewed with the monthly Quality Assurance Committee. **Compliance Date: 5/13/2011**	
K0051	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			

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SS=E	Based on observation and interview, the facility failed to ensure 4 of 159 smoke detectors were installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could effect residents in and near each of the corridor smoke detectors, including staff and visitors. Findings include: Based on observations with the maintenance supervisor and facility administrator on 04/13/11 between 11:40 a.m. and 2:00 p.m., the smoke detectors near resident rooms 23, 27, 52 and the clean laundry room were located within two feet of an air supply duct. The problems were acknowledged by the maintenance supervisor at the time of the observations.	K0051	K051 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · No actual harm to any residents, staff or visitors occurred.. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All residents, staff and visitors have the potential to be affected by this alleged deficient practice. · Smoke detectors will be moved to an area no less than 2 feet away from air vents. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · F.A.S.T. has been contracted to relocate the addressed smoke detectors to a distance of no less than 2 feet away from the air vents. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The Maintenance Supervisor/ designee will do an inspection of the smoke detectors within this facility for proper placement. Any other smoke detectors not in compliance will be relocated by F.A.S.T.	05/13/2011

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	3.19(b)		· Completion and inspection of this work will put the facility in substantial compliance and results will be reviewed by the Quality Assurance Committee.. **Compliance Date: 5/13/2011**	
K0062	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
SS=F	1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for Water Based Fire Protection Systems 10-2.2. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the maintenance supervisor and facility administrator on 04/13/11 at 10:50 a.m., the sprinkler system reports supplied by Reliable Fire dated 01/10/11, 10/12/10, 06/18/10 and 03/23/10 provided no	K0062	K062 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Reliable has been contracted to do an internal pipe inspection. · Reliable has been contracted to replace the 2 sprinkler gauges dated 1997 and 2005. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All residents, visitors and staff had the potential to be affected by this alleged deficient practice. · Inspections and repair work will be completed to meet LSC requirements. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Reliable will provide regular inspection reports to the facility.	05/13/2011

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	documentation to indicate an internal inspection of the dry sprinkler system had been completed in the past five years. The maintenance supervisor stated at the time of the record review he thought the system had been flushed and checked during system repairs in 2009. He did not present evidence of an internal pipe inspection. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 4 sprinkler gauges were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff and visitors.		· The Maintenance Supervisor/designee will monitor annually inspection reports to assure that inspections/repairs are completed in accordance to LSC requirements. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The Maintenance Supervisor/designee will monitor annually inspection reports to assure that inspections/repairs are completed in accordance to LSC requirements. · Reports will be reviewed by the · Administrator/designee will review these reports for any inspections, work or repairs that are recommended by a State Approved vendor. · Completion of any inspections, work or repairs that are completed will be reviewed with the Quality Assurance Committee. Compliance Date: 5/13/2011	

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	Findings include: Based on observation with the maintenance supervisor on 04/13/11 at 1:50 p.m., the two gauges were dated 1997 and 2005 on the face of the gauges. At the time of observation the maintenance supervisor stated that he was not aware of the problem. 3.1-19(b)			
K0066	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4			
SS=C	Based on observation and	K0066	K066	05/13/2011

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	interview, the facility failed to ensure 1 of 2 smoking areas had covered metal receptacles with self closing lids in areas where smoking was permitted. This deficient practice could effect staff and visitors in and near the approved smoking area. Findings include: Based on observation on 04/13/11 at 2:20 p.m. with the maintenance supervisor and facility administrator, the designated employee smoking area had an open trash receptacle with a hole in the top where cigarette butts were deposited with combustible trash. Hundreds of cigarette butts were scattered over the entire smoking area. Smoking towers were provided in the designated smoking area. The maintenance supervisor and the administrator acknowledged the problem. 3.1-19(b)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The current smoking and trash receptacles were removed and replaced with metal trash receptacles. The trash receptacle is equipped with a self-closing lid. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All residents, visitors and staff had the potential of being affected by this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Metal receptacles have been put in place at designated smoking areas. · No Smoking signs have been placed near exit doors of the facility. · Staff has been educated on the importance of smoking only in designated areas and proper use of provided receptacles. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Maintenance director/designee will observe	

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			smoking areas at least 3 times per week to assure compliance of smoking areas is adhered to. · Non-compliance to use of designated areas and policing of areas will be reported to the Administrator/ designee for further education/ disciplinary actions. · Non-compliance concerns will be reviewed by the Quality Assurance Committee for a plan of action to return the facility to total compliance. **Compliance Date: 5/13/2011**	
K0067	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2			
SS=E	Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 27 of 70 rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA (National Fire Protection Association) 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A 2-3.11.1 requires that egress corridors shall	K0067	K067 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident rooms 44-70 will have the adjoining bathroom exhaust fans wired to run constantly to meet the CMS guidelines for K67 HVAC Requirements. · The Ice Cream parlor will have a return air duct installed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All residents, visitors and staff have the potential to be affected by the alleged deficient practice.	05/13/2011

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	not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors in building 0202. Findings include: Based on observation on 04/13/11 between 12:50 p.m. and 1:45 p.m. with the facility administrator and maintenance supervisor, the following resident rooms were using the egress corridor as a return air system: 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69 and 70. Cooling is supplied by vents in the resident rooms and rely on the corridors of the SCU, D hall and the ice cream parlor for return ventilation. These rooms are located in building 0202. The maintenance supervisor acknowledged the deficiency and stated he was not aware of the problem.		· Air systems will be corrected to meet the LSC HVAC requirements. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All exhaust fans in the adjoining bathrooms to resident rooms 44-70 will have new motors installed and a keyed switch will be installed to assure these exhaust fans run continuously to provide constant air circulation. · A return air duct will be installed in the Ice Cream parlor. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Maintenance Director/designee will routinely check exhaust fans for proper operation. · Administrator/DON will be notified of any unit not functioning and ensure that repair/replacement is completed timely. · Completion of this work will be reviewed by the Quality Assurance Committee for compliance. **Compliance Date: 5/13/2011**	

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K0072	3.1-19(b) Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10			
SS=E	Based on observation and interview, the facility failed to ensure the means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency for 1 of 8 exits. This deficient practice could affect approximately 40 residents, staff and visitors using the SCU and D hall (southwest exit). Findings include: Based on observation on 04/13/11 with the maintenance supervisor at 2:15 p.m., the exit discharge for the SCU and D hall southwest exit was obstructed by a car being used by painters. The maintenance supervisor stated at the time of the observation he was not aware of the problem.	K0072	K072 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · A "No Parking" sign has been installed at the egress area of the facility SW exit near the Secure Unit. The painting contractor was contacted and advised of parking areas available for him and his staff. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · Residents on the secure unit may have been affected in the event that an evacuation of that unit would have been necessary. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · A "No Parking" sign has been placed in the area. · The Maintenance Supervisor/ designee will do random observations to this area to assure that an open egress is always available.	05/13/2011

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	155469	A. BUILDING 01 B. WING	04/13/2011

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	3.1-19(b)		How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Any obstruction to any egress area for this facility will be addressed immediately and reported to the administrator · Any reports of egress obstruction will be reviewed by the Quality Assurance Committee. Any patterns or continued non-compliance will require a Plan of Action to assure total compliance is maintained.. **Compliance Date: 5/13/2011**	
K0074	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3			
SS=F	1. Based on observation and interview, the facility failed to protect 138 of 138 residents by	K0074	K074 What corrective action(s) will be accomplished for those residents	05/13/2011

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	ensuring all draperies, curtains and valances serving as furnishings were flame resistant in accordance with LSC 10.3.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the facility administrator and maintenance supervisor on 04/13/11 between 11:15 a.m. and 2:30 p.m., the facility's common areas, lobby, ice cream parlor, emporium, therapy rooms and offices had draperies, curtains and valances that had no evidence or documentation of fire resistance or being treated with a fire retardant. The maintenance supervisor acknowledged at the time of observations he did not have evidence of fire resistance or materials being treated with a fire retardant. 3.1-19(b)		found to have been affected by the deficient practice? · Draperies, curtains and valances will be treated with fire retardant material, replaced or removed. · The shower curtains in the main unit shower rooms have been replaced with curtains that have a ½" mesh extending 18" below the sprinkler deflector.. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · These alleged deficient curtains could potentially affect any resident, visitor or staff. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Any curtains, drapes or valances that facility cannot provide fire certifications for will either be treated with an approved fire retardant treatment, replaced or removed. · The shower curtains were replaced with approved shower curtains that extend 18" below the sprinkler deflectors and have a open mesh for the upper 18" portion of the curtain.. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what	

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	2. Based on observation and interview, the facility failed to ensure sprinklers in areas where cubicle curtains are installed were installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems for 2 of 2 privacy curtains in the pink B hall shower room. This deficient practice could affect residents and staff in and near the facility's shower room including visitors. Findings include: Based on observation with the facility administrator and maintenance supervisor on 04/13/11 at 1:05 p.m., the facility's pink B hall shower room contained two privacy curtains that lacked 1/2 in. (1.3 cm) diagonal mesh or a 70 percent open weave top panel extending 18 in. (46 cm) below the sprinkler deflector. The maintenance supervisor at the time of observation acknowledged the privacy curtains did not meet the requirement.		quality assurance program will be put into place? · The facility will use only approved curtains/blinds to replace any curtains in facility. · The Maintenance Director/designee will maintain a log of any curtains, valances that are fire treated and assure they are retreated after washing/cleaning. · The facility will use only approved shower curtains when replacing shower curtains on the main unit. The Administrator will review and approve any replaced curtains for compliance before approving. · The order and placement of new curtains will be presented to the Quality Assurance Committee for review. Compliance Date: 5/13/2011	

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K0147 SS=F	3.1-19(b) Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure sufficient access and working space for 1 of 2 electrical rooms was provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment in accordance with NFPA 70, Article 110-26 which requires a minimum of three feet of clearance. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor on 04/13/11 during the tour at 12:25 p.m., the area between the electrical panels and the generator transfer switch in the main electrical room had numerous boxes, bags and equipment stacked on the floor, limiting access to the electrical	K0147	K147 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · This area has been cleared of any stored items within a 3 foot area immediately in front of the electrical panels. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. · All resident, visitors and staff had the potential of being affected by this alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Maintenance Supervisor/ designee will observe this area daily to assure that area is clear of any obstructions. Environmental staff were in-serviced on the importance of keeping electrical areas clear of obstructions. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put	05/13/2011

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	equipment. Based on interview at the time of observation, the Maintenance Supervisor indicated the materials had belonged to deceased residents and had not yet been disposed of. 3.1-19(b)		into place? · Administrator will observe this area weekly to assure it is clear of obstacles. Any occurrences of non-compliance may result in disciplinary action and review of non-compliance by the Quality Assurance Committee. Compliance Date: 5/13/2011	